# Wisconsin Department of Safety and Professional Services

**Mail To:** **P.O. Box 8935**
**Madison, WI 53708-8935**
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
**Phone #:** **(608) 266-2112**
E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov

## MEDICAL EXAMINING BOARD

APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY
FOR INDIVIDUALS WITH A CURRENT UNRESTRICTED MINNESOTA LICENSE

(This application does not apply for individuals who hold a Minnesota Telemedicine license.)

**Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).**

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

| Last Name | First Name | MI | Former / Maiden Name(s) |
|---|---|---|---|
| | | | |

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

**Sex:** ☐ M ☐ F

**Ethnic:** ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

**Medical School:** _____
**School Address:** _____
(City) (State/Country)
**Degree:** _____
**Date Degree Granted:** _____
month/day/year

**Select only one code.**
**(For a list of specialty codes see Form #546)**

**Specialty:** _____

**Specialty Code:** _____

**APPLICATION FEES** **Make one check payable to DSPS for the total DSPS fee and attach to this application.**

**For Receipting Use Only**

____ **Reciprocity of MN State Board License**
$ 141.00 Reciprocal Initial Credential Fee
$ 75.00 State Law Exam
**$ 216.00 Total Fee Attached***

***ORAL EXAMINATION INTERVIEW FEE: $266.00**
If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

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**APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:**

| | |
|---|---|
| Application (Form #2862) | Physician Profile Data Report from the American Medical Association or American Osteopathic Association |
| National Practitioner Data Bank Report | Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445) |
| Copies of malpractice suit. Court documents with allegations and settlement. (If apply, complete Form #2829 Malpractice Suits or Claims Form) | Fee attached to application (Form #2862) |
| Provide a current copy of unrestricted Minnesota license | Wisconsin Statutes and Rules Examination |
| | Convictions & Pending Charges Form (Form #2252 **if applicable)** |

**IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.**

SPECIALTY BOARD CERTIFICATIONS _____ Yes _____ No DATE CERTIFIED _____
mo / day yr

**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary.

| | | YES | NO |
|---|---|---|---|
| 1. | Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases? | ❑ | ❑ |
| 2. | Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency. | ❑ | ❑ |
| 3. | Have you ever failed to pass any state board examination, national board examination, or USMLE, or FLEX examination? If yes, give details on an attached sheet. | ❑ | ❑ |
| 4. | Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action. | ❑ | ❑ |
| 5. | Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action. | ❑ | ❑ |
| 6. | Do you have any felony or misdemeanor charges pending against you? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. | ❑ | ❑ |
| 7. | Have you ever been convicted of a misdemeanor or a felony? If yes, submit Convictions and Pending Charges (Form #2252). Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges. | ❑ | ❑ |
| 8. | Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer. | ❑ | ❑ |
| 9. | Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition. (If yes, complete Form 2829.) | ❑ | ❑ |
| 10. | Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet. (If yes, the institution must complete Form 2167.) | ❑ | ❑ |
| 11. | Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s). | ❑ | ❑ |

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| | | YES | NO |
|---|---|---|---|
| 12. | Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under. | ❑ | ❑ |
| 13. | Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet. | ❑ | ❑ |

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

| | | YES | NO |
|---|---|---|---|
| 14. | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain. | ❑ | ❑ |
| 15. | Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain. | ❑ | ❑ |
| 16. | Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | ❑ | ❑ |
| 17. | Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | ❑ | ❑ |
| 18. | Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | ❑ | ❑ |
| 19. | Are you currently engaged in the illegal use of controlled dangerous substances? | ❑ | ❑ |
| 20. | If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | ❑ | ❑ |

# Wisconsin Department of Safety and Professional Services

**CERTIFICATION OF LEGAL STATUS.**

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

**ALL APPLICANTS MUST COMPLETE THIS SECTION**

**AFFIDAVIT OF APPLICANT**
**(Sign and date in the presence of a notary)**

**I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.**

_____ _____
Signature of Applicant Date

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____
(Applicant name)

_____
Signature of Notary Public

**S E A L**

_____
Date Commission Expires

# Wisconsin Department of Safety and Professional Services

**SOCIAL SECURITY NUMBER**. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

**Profession**

Date of Birth _____ month _____ day _____ year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department ofChildren and Families for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

**EMAIL ADDRESS:**

**Do you have an email address?** ☐ **Yes** ☐ **No**

**If yes,** this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

**EMAIL ADDRESS:** Submit your email address in the spaces provided below or attach a printer copy.

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**If no,** your checklist will be sent by first class mail.

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.